



2009 Medicaid Transformation Program Review Medicaid Funded School-Based Services

Description

A Local Education Agency (LEA) is defined by the U.S. Office of Special Education Program as “a school district, board of education, or other public authority under the supervision of a state educational agency having administrative control and direction of a public elementary or secondary schools in a city, county, township, school district, or political subdivision in a state.” The Individuals with Disabilities Education Act (IDEA) guarantees every child a free and appropriate public education (FAPE). Kansas Medicaid will reimburse LEAs for medically necessary services required for a Medicaid eligible child to receive FAPE as documented in the child’s individual educational program (IEP) or individual family service plan (IFSP).

LEA services are available for any child with a disability. A child with a disability is defined by IDEA as “a child with mental retardation, hearing impairments (including deafness), speech or language impairments, visual impairments (including blindness), serious emotional disturbance (hereinafter referred to as ‘emotional disturbance’), orthopedic impairments, autism, traumatic brain injury, other health impairments, or specific learning disabilities; and who, by reason thereof, needs special education and related services.”

Special education services may be provided directly through the unified school district or through a contract. Special education contracts may be made with an individual, association, agency, organization, or other agency. Kansas Medicaid refers to these special education service contracts as cooperative agreements or interlocal agreements. The majority of the school districts in the state of Kansas have entered into a contract with either a special education cooperative (contract made through a cooperative agreement) or interlocal (contract made through an interlocal agreement). These contracted entities employ and manage special education staff including therapists and paraprofessionals. Under the contracts, the special education cooperatives and interlocals bill Kansas Medicaid for their staff medical services.

Prior to state fiscal year (SFY) 1997, Kansas Medicaid reimbursed LEAs for medical school-based services provided for Medicaid eligible, special education students using the traditional fee-for-service (FFS) methodology. The FFS rates were established by the State of Kansas based on the existing community FFS rate paid by Kansas Medicaid for comparable services provided through the Medicaid state plan. Services reimbursed include:

- health screening
- medical transportation
- nursing services
- occupational therapy
- physical therapy

- speech therapy
- language and hearing therapy
- vision services

In 1997 Kansas Medicaid implemented a bundled rate methodology for school-based services. This method of claim billing and reimbursement consisted of nine disabilities or exceptionalities:

- Occupational Therapy (OT)
- Speech Therapy (SLP)
- Physical Therapy (PT)
- Health Screening
- Skilled Nursing
- Vision Services
- Transportation
- Rehabilitative Assistance
- Behavioral Rehabilitation

Each disability or exceptionality was given a local procedure code for billing purposes and a bundled, monthly lump sum reimbursement rate. This up-front payment was made to LEAs on behalf of each eligible child in their district who was identified through an IEP to have one of the designated exceptionalities. This reimbursement amount was calculated to cover intense medical services reflecting the nature of the disability or exceptionality. In 1998 Kansas Medicaid expanded LEA coverage to include licensed practical nurse (LPN) services, skilled nursing services, and supervisory visits for children who required attendant care in the school setting. Also in 1998 a new bundled code applied to children described as “Developmentally Delayed”. This code was allowed for children ages 3 through 9 years old.

In 2005 and 2006 the Department of Health and Human Services Office of Inspector General conducted five audits on school based services in Kansas:

- Bundled Rate Development (A-07-05-01018)
- Adjustment of Bundled Rates (A-07-09-01030)
- Health Services (A-07-03-00155)
- Application of Bundled Rates (A-07-04-01003)
- School District Administrative Claiming (A-07-03-00154)

The objective of the audit on the development of bundled rates was to determine whether Kansas developed the payment rate for Medicaid school-based health services according to the Federal requirements and the State plan. A summary of the findings concluded that Kansas did not meet these requirements: Kansas used incorrect indirect cost rates and service utilization data to develop the payment rates, and Kansas did not have adequate internal controls to ensure that it correctly developed the payment rates. As a result, the payments to school districts for FYs 1998 – 2003 were incorrect, and Kansas received \$18.5 million of overpayments. KHPA agreed with the findings.

The objective of the audit on the adjustment of bundled rates was to determine whether Kansas adjusted the payment rates for Medicaid school-based health services in line with Federal regulations. A summary of the findings concluded that Kansas did not. Specifically, Kansas did not adjust the payment rates for inflation consistent with the costs that it used to develop the rates. Kansas had inadequate internal controls to ensure that it correctly adjusted the payment rates. As a result, each of the 15 payment rates was overstated as of May 2003.

The objective of the Health Services audit was to determine whether Kansas claimed costs for school-based health services provided by selected school districts for FY 2002 in accordance with Federal requirements and the State plan. A summary of the findings concluded Kansas claimed some costs that were not in accordance with Federal requirements or the State plan. This occurred because Kansas provided incorrect or inadequate instructions to local school districts on submitting claims for Medicaid school-based services to the State for reimbursement. Among the unallowable services were therapy services that were rendered without a physician's prescription documented. As a result \$5.1 million was determined to be unallowable. Subsequent to these findings OIG stated that many sampled claims lacked documentation for such items as place of service, type of service rendered, and units of service provided. OIG did not calculate the costs of these subsequent findings but brought the findings to Kansas' attention.

The objective of the audit on the application of bundled rates was to determine whether Kansas claimed costs for Medicaid school-based health services consistent with the design of the bundled payment rates and according to Federal regulation and the State plan. A summary of the findings concluded Kansas did not reimburse school districts consistent with the payment rates' design or pursuant to Federal regulations and the State plan. Kansas designed the monthly payment rates to reimburse school districts for a full year's costs over nine school months. However, these rates were used to reimburse the school districts for 12 months. The reimbursements for service months outside the traditional school year represented payments in excess of costs. For FYs 1998 – 2003, the Federal share of the excessive reimbursement was \$13.9 million.

The objective of the school district administrative claiming audit was to determine if Kansas used accurate time studies and cost reports to claim Medicaid administrative costs associated with school-based services for FY 2002 in accordance with Federal guidelines. A summary of the findings concluded Kansas used inaccurate time studies and cost reports, and therefore did not claim Medicaid reimbursement for administrative costs associated with school-based services for FY 2002 in accordance with Federal regulations. Kansas did not ensure that completed time study forms represented actual activities performed or that school districts submitted accurate and reliable cost reports. This audit resulted in an identified recoupment amount of \$347,047.

Taken as a whole, the audits found inadequate documentation and financial controls to assure that Kansas Medicaid's payments to LEAs could all be tied to approved services rendered by authorized providers to Medicaid-eligible children and reimbursed at an appropriate and approved rate. As a result of these audits, KHPA repaid the federal government over \$37.8 million. There was also a potential for additional and significantly larger repayments. To come into compliance with CMS requirements and to avoid additional reimbursements to CMS, KHPA made the following changes to the school-based services program:

- In December 2005 Kansas required school districts to obtain physician prescriptions for all therapy services.
- In February 2006 Kansas hired a new contractor for the school district administrative claiming program.
- Since 2006 Kansas has continuously updated the LEA provider manual with explicit documentation requirements.
- In July 2007 Kansas discontinued the bundled rate codes. School districts were required to bill and receive reimbursement through the traditional fee-for-service methodology,

thereby establishing a clear audit trail and a direct link, through the state's Medicaid payment system, between a Medicaid provider, a Medicaid beneficiary, and a Medicaid payment rate.

LEAs are reimbursed by Kansas Medicaid for administrative activities performed by the schools in support of the state Medicaid program which include outreach, enrollment, and support in gaining access to early periodic screening diagnosis and treatment (EPSDT) services. Reimbursement made to the LEAs for administrative activities is referred to as the school district administrative claiming (SDAC) program. This is an optional Medicaid program and LEA participation is voluntary. Kansas Medicaid has contracted with Public Consulting Group (PCG) to manage the SDAC program. This contractor collects the data and provides the analysis required to receive payments through this program. An average of \$3.4 million is reimbursed to LEAs annually through this program.

The Centers for Medicare and Medicaid (CMS) finalized regulation CMS-2287-F in 2008, which would have prohibited Medicaid payments to the LEAs for administrative activities performed by the schools in support of the Medicaid program. This rule also eliminated payment to the schools for the transportation of school-age children to and from school. This rule was one of several CMS Medicaid regulations held up in a series of Congressional moratoria. The finalized regulation was eventually rescinded by CMS in 2009. Kansas Medicaid does not reimburse LEAs for transportation of school-age children to and from school, so that portion of the regulation would not have had an impact on Kansas Medicaid. However, CMS' reversal on this regulation preserves an important funding source for schools, and signals new stability in the Federal government's overall view of Medicaid reimbursements for LEA services.

Service Utilization and Expenditures

The utilization of LEA services changed markedly in July 2007 following the implementation of KHPA policy E2007-026, which discontinued the use of bundled disability codes and required the LEAs to bill traditional FFS codes. A sharp decline was identified in the consumer counts and total expenditures between State Fiscal Years (FY) 2007 and 2008 as shown in Figures 1 and 2.

With the reinstatement of a traditional FFS reimbursement methodology, LEAs are required to bill and be reimbursed for each medical service provided to each specific child. The decrease in expenditures, seen in Figure 2, can be explained by the transition from a monthly bundled payment methodology loosely tied to utilization to a fee for service methodology directly tied to specific, documented services. To some extent, the drop validates the findings from CMS' series of audits, which questioned the relationship between expenditures and services. It is less clear why the number of children receiving services also fell. It is possible that schools struggled, in the first year of implementation of the FFS methodology, to successfully document and bill for all LEA services. Further research with more recent data may shed more light on the reduction in both spending and recipients.

Figure 1 – Medicaid Beneficiaries Receiving School-Based Services by FY

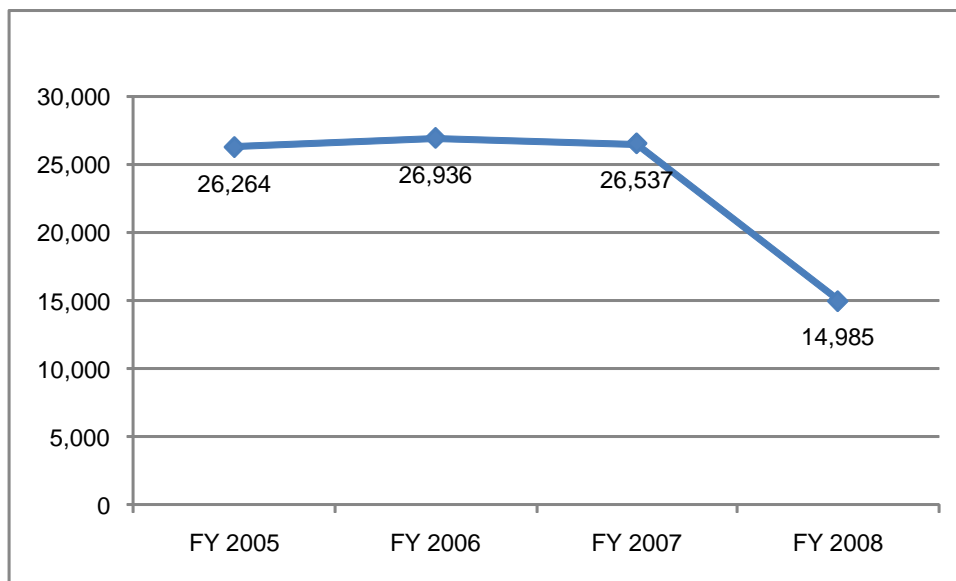
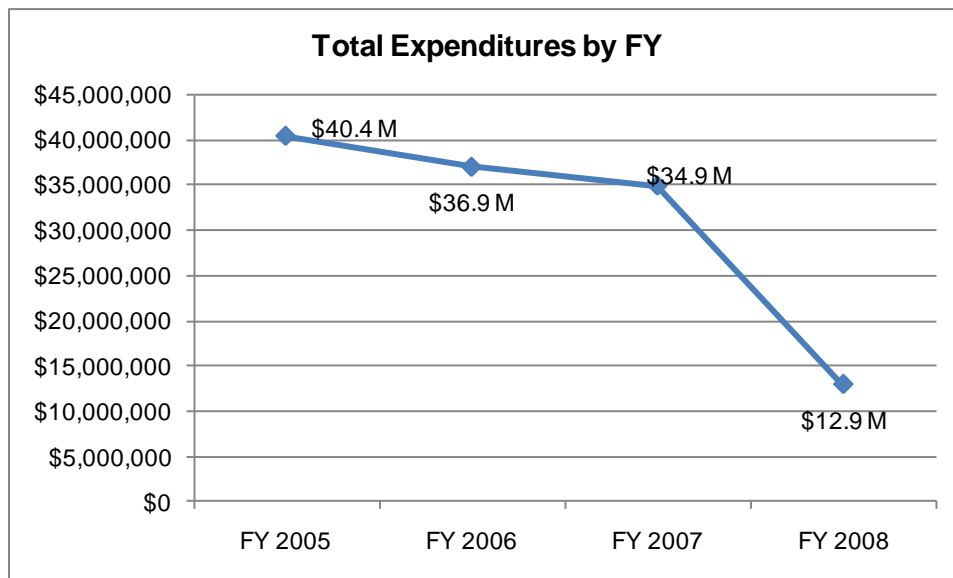
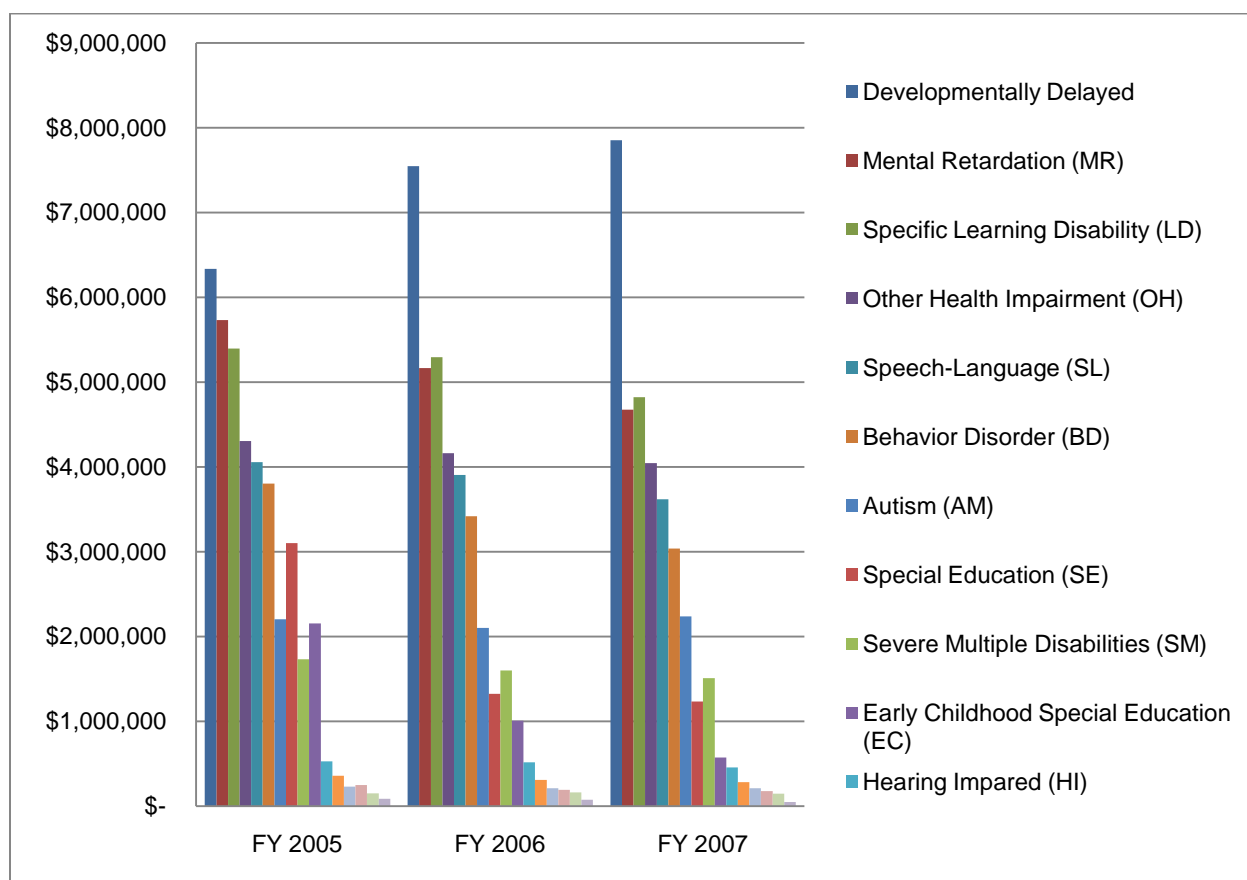


Figure 2 – Total Expenditures for School-Based Services by FY



Prior to FY 2007, LEAs billed exceptionality codes to Kansas Medicaid. Those codes were created to reflect a child's disability (i.e. autism, developmentally delayed, speech language pathology). Details about the level of care given on a daily basis were not discernible through the billing process since disability codes were reimbursed at a monthly bundled reimbursement rate regardless of the amount of medical care provided in the school setting. Figure 3 depicts the expenditures for each exceptionality code in ascending order by cost. In 1998 the "developmentally disabled" exceptionality code was created. This code was associated with the exceptionality of the majority of LEA consumers.

Figure 3 – Expenditures by Exceptionality FY 2005-2007

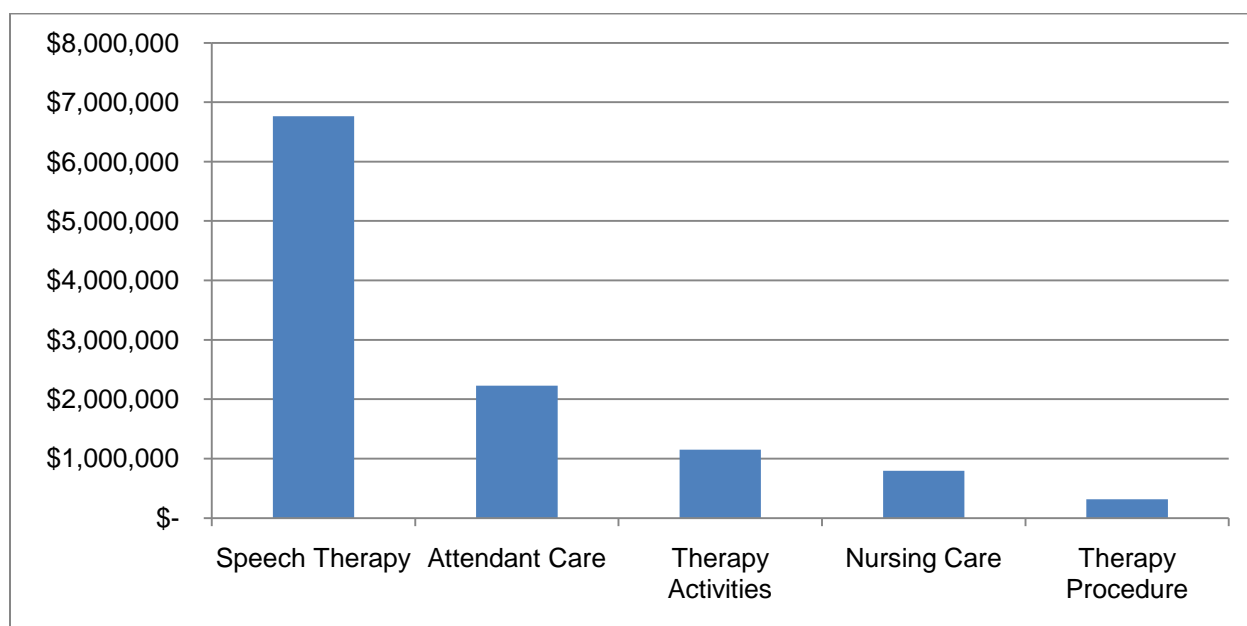


Medical providers use procedure codes and diagnosis codes to submit claims to insurance companies. A procedure code indicates a specific medical service rendered to a beneficiary. A diagnosis code indicates the medical condition or specific reason a medical service was provided to a beneficiary. Figures 4 and 5 categorize the top five procedure and diagnoses codes.

Kansas Medicaid reimburses LEAs for medically necessary services which may be habilitative or rehabilitative intended to yield the maximum reduction of disability and restoration to the best possible functional level. Therapy is provided only for individuals with a physician treatment plan, an individual education plan (IEP), or an Individualized Family Service Plan (IFSP). All therapies require a physicians order. Speech language therapy in either an individual or group setting is the largest expenditure billed by LEAs.

Figure 4 presents the top procedure codes, or medical services, provided for special education students for state fiscal year 2008. Speech therapy is the top expenditure for LEAs.

Figure 4 – Highest Expenditure Services for FY 2008



Attendant care consists of medically necessary services provided by a paraprofessional. Attendant care must be documented in a physician treatment plan, an IEP, or an IFSP. A paraprofessional is referred to as a one-on-one instructional assistant. Paraprofessional responsibilities include: providing direct instruction, redirection, guidance, and personal care for a child. Attendant services considered educationally necessary, but not medically necessary, are not reimbursed by Kansas Medicaid. Attendant care services are available to disabled students so that they may receive their education in the least restrictive environment.

Physical and occupational therapeutic activities that further improve, develop, or restore functional skills are included in the top five procedures identified by expenditure. Therapeutic activities engage the child in activities, tasks and roles for the purpose of meeting a requirement of living.

Nursing care, by a licensed practical nurse (LPN), is reimbursed by Kansas Medicaid when documented in the student's physician treatment plan, IEP or IFSP. LPN services may provide skilled nursing care within scope of practice in the home or in the school setting. Nursing services in the home are permitted if medically necessary for the child to receive a free and appropriate public education. Home nursing services must be documented in the child's IEP.

Figure 5 depicts the five most frequently billed diagnoses, or medical conditions, as indicated on LEAs claim submissions. The diagnosis defined as "lack of normal physiological development" is used for claim submission 98% of the time for children receiving special education medical services.

The Individuals with Disabilities Education Act (IDEA) states "Nothing in this Act requires that children be classified by their disability so long as each child who has a disability listed in sec. 1401 and who, by reason of that disability, needs special education and related services is regarded as a child with a disability under this part." Kansas Medicaid uses this section of IDEA

for guidance and determination that diagnosing a child with broad diagnosis code is an acceptable billing practice for LEA services.

Figure 5 – Most Frequent Diagnoses Billed by LEAs FY 2005 – 2008

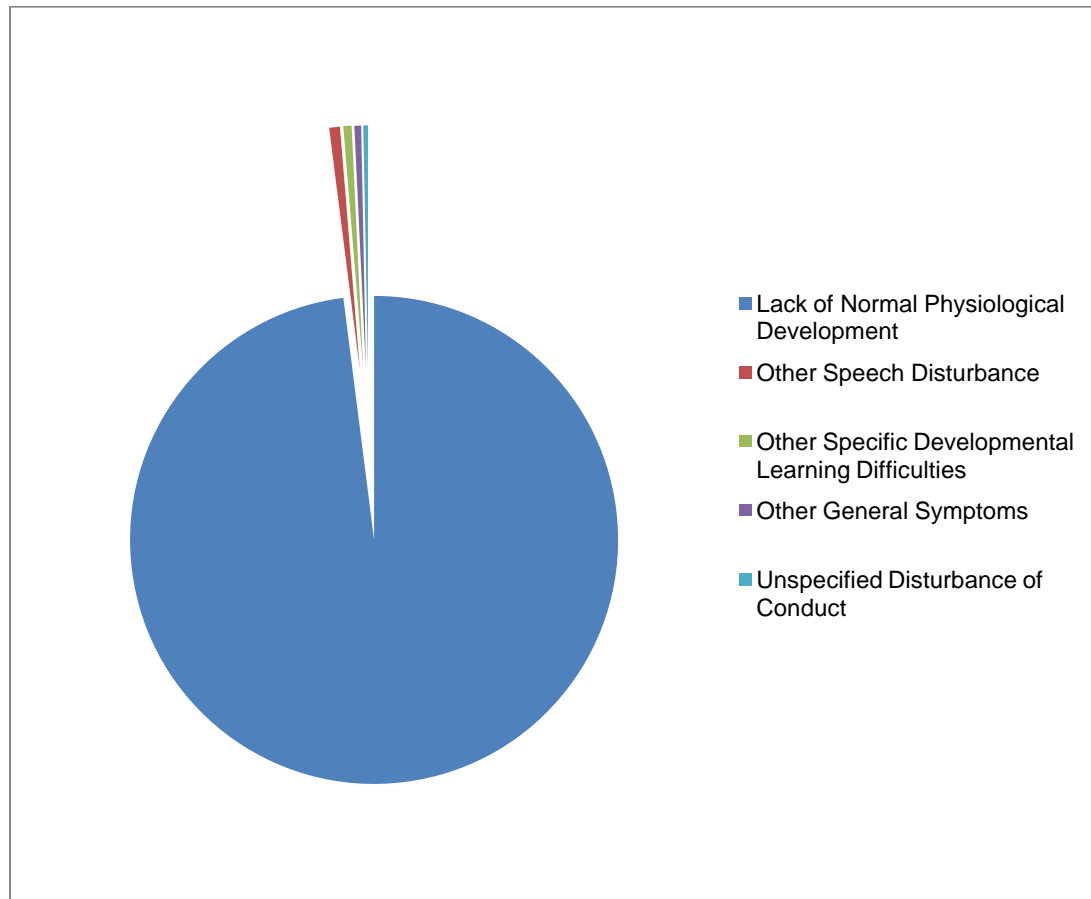


Figure 6 displays data on LEA services provided for three specific Medicaid eligible populations.

- The disabled population includes those beneficiaries who were granted Kansas Medicaid health coverage due to a disabling status. This population would have been granted this status by applying for disability through the Supplemental Security Income (SSI) program. The disability population includes the blind, disabled and Ticket to Work.
- The family population includes those beneficiaries who were granted Kansas Medicaid health coverage through the temporary assistance to families (TAF) program or are a family or pregnant woman of low income.
- The third population includes children who are institutionalized or a person who has become a refugee.

Most children receiving Medicaid services in a LEA tend to present a developmental delay, which in itself, would not qualify for SSI disability. The majority of LEA services are provided to children in the Temporary Assistance for Needy Families (TANF) population. The disability population represents the second greatest volume population using LEA services.

Figure 6 – Expenditures by Population Group by Fiscal Year

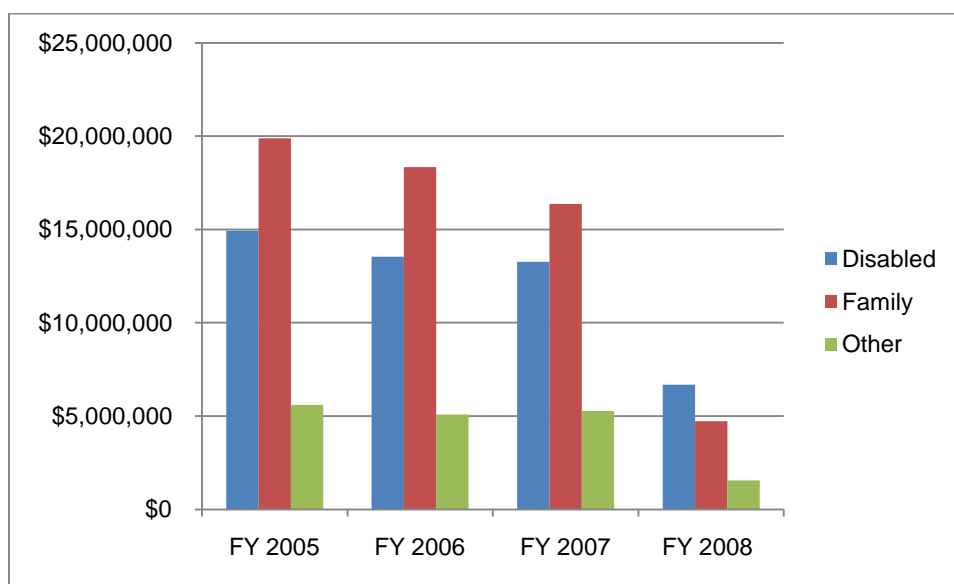
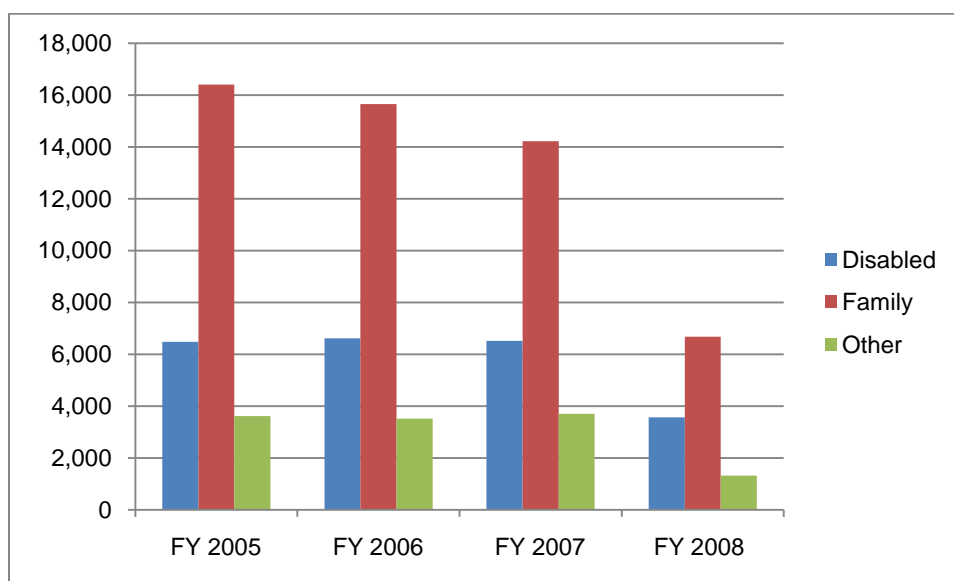
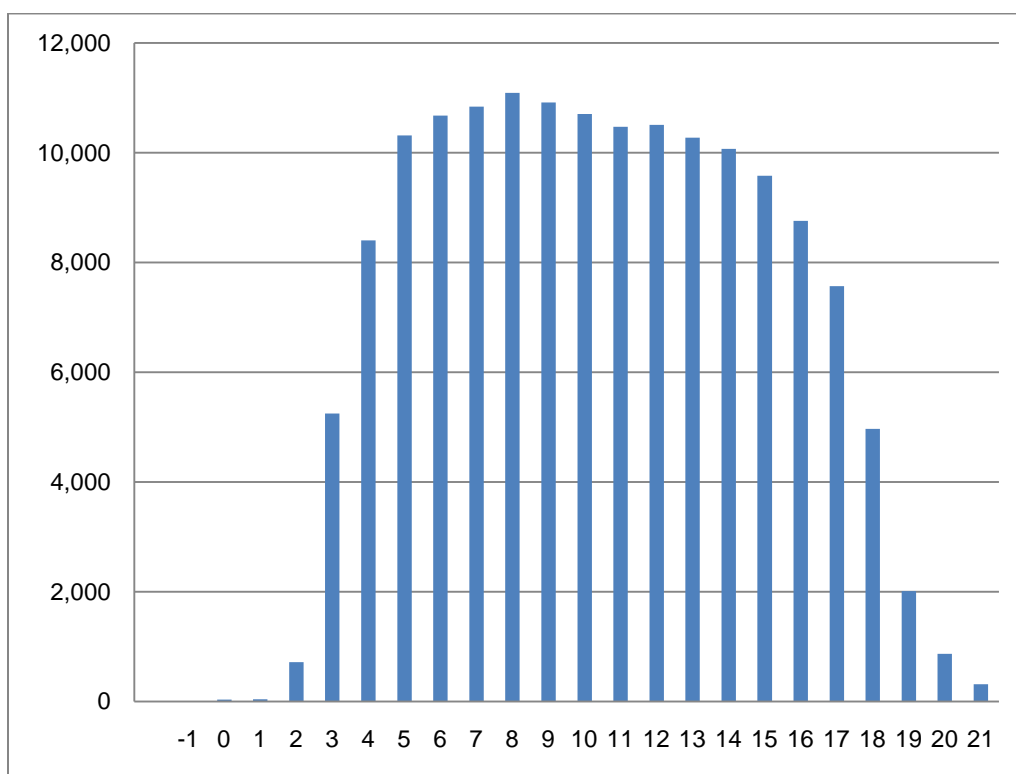


Figure 7 – Beneficiary Volume by Population Group by Fiscal Year



Most of the users of LEA services are school aged children. As seen in Figure 8, the majority of services provided in an LEA setting are for children ages 5 through 13 years of age. A limited amount of care is provided for older children ages 20 – 21 years of age. Since special education student can remain in school through age 21, children who have severe disabilities, may not graduate from their secondary education and continue to receive services in the school setting. Services for those older Medicaid students require an active IEP. At age 21 years, those children will age out of the LEA program.

Figure 8 – Age Distribution of Beneficiaries Receiving LEA Services FY 2005-2008



Program Review

As identified in the 2005 and 2006 audits, LEAs must obtain a physician's order to provide therapy services to a child. In many cases a child's family has not identified a medical home and does not see a physician routinely for medical care. When a child in this situation enrolls in the public school system and is identified with an exceptionality and possible need for therapy services, a physician's order is not obtainable. LEAs have struggled to bridge the medical gap in their special education programs. KHPA would like to explore opportunities to work with the Kansas Department of Education, LEAs and physicians in encouraging families to identify a medical home.

The school-based service program has undergone significant changes in the past five years. More stringent federal regulations have been enforced at the state level to ensure school districts are provided financial support for medical services that are required by IDEA. KHPA has developed a strong relationship with LEAs and is looked to provide guidance for the provision of direct medical services in the school setting paid for by Kansas Medicaid. Ongoing changes to school-based services at a local and national level continue to be monitored by KHPA and shared with LEAs as they occur.

During 2005 and 2006 the federal Office of the Inspector General (OIG) conducted five audits on LEAs which identified several payment methodology issues related to school-based administrative activities and the bundled payment rate design. In 2007 an agreement negotiated by KHPA was reached between the State of Kansas and the Centers for Medicare and Medicaid (CMS) which resolved all the outstanding administrative and payment issues

identified by CMS. Resolution of the issues was contingent upon implementation of the agreed-to reforms on July 1, 2007 to bring the State into full compliance with all Federal regulations and State Plan provisions. The corrective actions taken to address the findings of the OIG audits of LEAs included:

- The LEA provider manual was revised to clearly state that physician orders are required for physical, speech, occupational, and other therapies
- The previous contractor to revise administrative claiming processes was replaced with Public Consulting Group
- The bundled rate methodology, which was no longer allowed by CMS, was replaced with a fee-for-service payment

Under the fee-for-service payment methodology reimbursement for LEA services is based on a fee schedule established by the State of Kansas. The rates are based on commercial third party payer, market rates, and the existing community fee-for-service rate paid by Kansas Medicaid for comparable services provided through the Medicaid state plan.

During the process of transitioning from a bundled rate methodology to a fee-for-service payment system, KHPA convened a Medicaid-bundled Rates Advisory Committee to advise the agency on how proposed changes in Medicaid reporting and possible cuts in federal funding would affect the schools and the special needs children they were serving. School superintendents expressed concern that the new payment methodology would result in a loss of significant revenue. Previously service intensity was not captured under the bundled rate so there was no comparable data to calculate how much income would be generated by the schools under the fee-for-service payment scheme. KHPA agreed to examine the adequacy of the payment structure after the schools had collected data on the actual cost of providing services. During FY 2008, school districts were instructed to keep an accounting of their actual costs in delivering LEA services to Medicaid beneficiaries.

Recent analysis of the cost data collected by the schools has resulted in a request to CMS for approval of a Medicaid State Plan Amendment (SPA) to reimburse for school-based services through a cost settlement process. This will allow KHPA to provide interim reimbursements to school districts based on fee-for-service rates and then reconcile to the school districts' actual costs during the close of the state fiscal year, resulting in a payment level adequate to assure Medicaid beneficiaries have access to services.

Recommendations

1. Improve LEA reimbursement to better cover the costs of the care provided by actively working to develop LEA cost-based reimbursement.
 - a. This effort is supported by an evolving set of Federal policies governing payment for school-based services.
 - b. Interim payments will be through the existing Medicaid fee schedules, with a subsequent annual cost settlement.
 - c. The cost settlement will be through the certified match process, taking advantage of local resources that are already being spent on these activities. Schools will certify the state share and school-specific costs will be documented through the submission of a cost report.
 - d. Cost-based reimbursement is expected to increase Federal payments for LEA services by an estimated \$23 million in FY 2011, but it is not yet known by how

much. With this implementation, Kansas will have come into full compliance with Federal rules, and with full Federal participation in LEA costs.

2. Continue monitoring LEAs for compliance with the post-OIG audit corrective action plan through our fiscal agent surveillance utilization review unit.
 - Ensure school districts obtain physician orders for therapy services provided.
 - Verify that school districts obtain supporting documentation for health-related services. Supporting documentation required:
 - the date of service
 - a description of the services provided
 - the name of the service provider
 - the duration of the service
 - a description of the progress made toward achieving individualized goals
3. Continue to coordinate school-based services policy with Kansas Department of Education. This relationship will ensure that policy is well thought through and communication with the schools is clear and consistent.
4. Collaborate with the Department of Education and LEAs to promote the identification of a medical home by Medicaid beneficiaries receiving school-based services.